52 Saner: *Gastro-enterostomy;* Cassidy: *Achalazia*

Case of Gastro-enterostomy.

By F. D. SANER, F.R.C.S.

W. G., MALE, aged 50. The history of this case extends over the past twenty-four years, includes five major abdominal operations and an almost uninterrupted record of dyspeptic symptoms.

1907-1912.—Vague dyspeptic symptoms.

1912.—Acute suppurative appendicitis. Operation. Drainage.

States that after this dyspeptic symptoms became worse and he dates his troubles definitely from this time.

1913, June.—Admitted to Lewisham Infirmary with a perforated duodenal ulcer. Operation, closure, perforation and drainage.

1913, October.—Since previous operation had continued to suffer with dyspeptic symptoms. In October was re-admitted to Lewisham Infirmary and a gastro-enterostomy was performed.

1913-1924.—No definite improvement. Discomfort was experienced after any meal, and diet did not alter this. Never any actual pain.

1924, February.—Admitted to St. John's Hospital, Lewisham, under Dr. Jackson. Symptoms much the same as before, only increasing in intensity; especial complaint of pain in epigastrium and left lower chest.

X-ray Report (summary).—Pylorus closed. The opaque meal leaves by the gastro-enterostomy opening at a great rate, and within ten minutes is entirely collected in the small intestine. No evidence on which to base suspicion of jejunal ulcer.

Operation, Laparotomy (F.D.S.). Stomach rather low in position but good tone. Gastro-enterostomy opening easily admitted hand. Closed so as to admit two fingers. Pylorus patent.

1924, July.—No improvement in symptoms.

X-ray Report (summary).—Meal was found to have left stomach completely within five minutes. Laparotomy (F.D.S.). Gastro-enterostomy closed.

1924-1926.—Pain present every day for eighteen months. Relief obtained at various times during day but never for whole day. Improvement for six months (April to November, 1926). Freedom from pain for periods two to three weeks at a time. In November symptoms recommenced as before.

1927.—Pain became severe and more persistent; present at night; subject to exacerbations, but patient now never completely free from it. A tender "tumour" can now be palpated in epigastric region, a feature not previously noticed.

X-ray Report, January 14, 1927.—Stomach dilated and ptosed. Some pyloric and pre-pyloric deformity. Pylorus does not function well and appears constricted. Stomach takes over six hours to empty.

Case of Achalazia.

By MAURICE CASSIDY, M.D.

T. N., AGED 60, a printer's warehouseman, complains of difficulty in swallowing of about ten years' duration. He cannot remember whether his symptoms commenced abruptly or gradually, but thinks that they have not varied much since their onset. Immediately on swallowing any kind of food, solid or liquid, he experiences a sense of discomfort under the lower end of the sternum which rapidly merges into a pain of great severity between the shoulder blades; the pain often makes him writhe,

and continues for a short time until he regurgitates; regurgitation always relieves the pain completely. He does not think that he regurgitates the whole of the food swallowed. Recently the difficulty in swallowing has gradually increased, a larger proportion of the food swallowed being returned. He has lost between three and four stone in weight during the last four years.

On admission he was pale and emaciated, weighing only 7 st. 2 lb. in a dressing gown. On examination of the chest and abdomen nothing abnormal was detected except a little bronchitis. X-ray examination revealed an enormous dilatation of the whole œsophagus due to obstruction at the cardiac orifice. The Wassermann reaction was negative; examination of the œsophageal contents, and of the resting gastric juice, and of the juice one hour after a meal, revealed absence of free hydrochloric acid in each instance. A mercury bougie was introduced into the œsophagus and it passed without any difficulty; the results were unsatisfactory, however, at first because, as proved radiographically, on many occasions the bougie did not enter the stomach but engaged in a pocket at the dilated lower end of the œsophagus.

On January 28 œsophagoscopy was performed by Mr. Howarth, who dilated his cardiac orifice by means of a special metal expanding dilator. On February 12 he was put on inj. atropine, $\frac{1}{100}$ gr. b.d., and luminal, $\frac{1}{2}$ gr. o.n.

As a result of two months' treatment the patient has improved considerably and gained 14 lb. in weight. He never regurgitates more than twice a day, often only once; the amount regurgitated rarely exceeds half a teacupful. He continues to pass the mercury bougie before each feed. Advice is asked as to the future treatment of this case.

Dr. CASSIDY said that this seemed to be a straightforward case of achalazia which after some initial difficulties had progressed very satisfactorily up to a point. Though there was an enormous improvement in the general condition of the patient, who could now swallow a fluid diet easily after passing a mercury bougie, solid food could not be taken, and he (Dr. Cassidy) doubted whether the patient would be able to dispense with the bougie. He was not inclined to advise surgical treatment. Walton had reported a successful series of cases treated by digital dilatation of the cardia after gastrostomy, but in two cases at St. Thomas's Hospital so treated by Maybury and Howarth the results had not been satisfactory. Œsophagogastrostomy, and the operation proposed by Rowlands based on Rammstedt's operation, had also been considered.

By the kindness of Dr. Adrian Stokes the Section had had the opportunity of seeing the very beautiful and convincing histological preparations prepared by Mr. Rakes, of Guy's Hospital. Dr. Cassidy thought that those who had seen these slides would agree that Mr. Rakes had established a morbid anatomy for this condition where previously there had been no recognized pathological basis.

Two Cases of Madelung's Deformity.

By C. C. LAMBRINUDI, F.R.C.S.

I. AND G. H., two sisters, aged 15 and 16 respectively.

Within six months of each other these patients were referred to the fracture department at Guy's Hospital by two different casualty officers, for pain and deformity of the wrist thought to have been produced by an injury.

On examination, there was marked deformity, the hand being carried forward, the ulnar styloid process was very prominent, there was some restriction of extension and an ill-defined feeling of weakness, insecurity and pain.

X-ray examination showed a forward curve of the lower end of the radius, a dislocation of the lower radio-ulnar joint, and an area of lessened density on the inner